Violence Against Women, Gender and Health Equity

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VIOLENCE AGAINST WOMEN, GENDER AND HEALTH EQUITY

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GLOBAL HEALTH EQUITY INITIATIVE

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ABSTRACT

This paper starts with a broad definition of violence against women and the different forms it takes, and then focuses on domestic and sexual violence in particular. It provides an overview of the magnitude of domestic and sexual violence against women and of its various consequences including those involving health for women and their children. It looks at the causes of violence, highlighting the links between violence against women and the cultural and social norms around gender, and other inequities, which perpetuate or exacerbate this violence. The paper suggests how a gender analysis may be useful to the violence field more broadly, and not just to violence against women. It discusses some of the limitations of current responses and makes recommendations for policy and programs. Finally it looks at some dilemmas or areas of controversy and identifies areas for further work.

"....women will not be free from violence until there is equality, and equality cannot be achieved until the violence and the threat of violence is eliminated from women's lives."

Canadian Panel on Violence Against Women, 1993

1. INTRODUCTION

Violence is a widespread and growing problem in practically all societies. It takes many forms, and occurs in all settings: at work, in the home, in the streets and the community at large. It affects both males and females of all ages, particularly young people. However there are important differences between women and men in the forms, the nature and the consequences of violence. Most violence is perpetrated by men, whatever the sex and age of the victim. Most significant is the fact that women and girls experience violence primarily at the hands of men they know and within the so-called 'safe haven' of the home and family. The response of society to the different forms of violence also differs. While street violence is considered a crime by everyone and state intervention is seen as legitimate, most governments have been hesitant when it comes to acting, and even legislating, against domestic violence. Because it happens in what is often considered the 'private sphere' of the home, it is harder to document and to prevent and easier to ignore.

Twenty years of activism on violence by women's organisations is slowly changing this. In particular the last five years have seen a growing recognition of violence against women as a legitimate concern. It has become part of the international agenda: initially as a women's human rights issue at the World Conference on Human Rights in Vienna (1993), and as it related to sexual and reproductive health at the International Conference on Population and Development in Cairo (1994). The Platform for Action of the Fourth World Conference on Women in Beijing (1995) dedicated a whole chapter to violence against women with a number of recommendations for governments, non-governmental and multilateral organisations. More recently violence against women has also begun to receive attention as a public health issue, and has been taken up by international organisations such as the World Bank, the World Health Organization (WHO), and UNFPA, among others.

Violence against women is a complex and multidimensional problem. There are factors at the individual, household and societal level that put women at risk or alternatively may help to reduce the risk of violence. It is embedded within social and cultural norms that perpetuate inequality between women and men, and condone or even encourage discrimination against women, including the chastisement of women by men and others. Domestic violence in particular is the epitome of unequal power relationships between women and men. The Canadian Panel on Violence Against Women states in the introduction to its report that: *"It is abundantly and indisputably clear that women will not be free from violence until there is*

equality, and equality cannot be achieved until the violence and the threat of violence is eliminated from women's lives" (Canadian Panel on Violence Against Women, 1993).

Violence against women affects all spheres of women's lives: their autonomy, their productivity, their capacity to care for themselves and their children, and their quality of life. It increases their risk for a wide range of negative health outcomes and even death. Much of this violence happens to women primarily because they are women, which is why it has also been called gender-based violence. It carries great costs to the individuals who experience it, and also to society and to the many services and sectors, including the health care system, that have to respond to its consequences. It is therefore an important issue to consider when addressing health equity.

In spite of the growing recognition of violence against women and progress made in recent years, there is still a lack of basic information on the magnitude of the problem, the understanding of its root causes, and the factors that may be protective.[1] This is particularly true for developing countries. Responses have been fragmented and have tended to focus on providing care for those already experiencing violence, rather than on the search for effective prevention strategies. It is time to move from the stated concern about violence against women to the concrete allocation of the necessary funds to develop a better understanding of the problem, test interventions for their effectiveness and replicability, and begin to address this problem in realistic and cost-effective ways.

Violence against women or gender-based violence can take many forms. It includes domestic violence, forced sex and other forms of sexual violence, trafficking of women as well as other forms that are specific to certain countries such as dowry related deaths, female genital mutilation and other traditional harmful practices. It can also happen in different locations and situations, such as in the home, in custodial situations (prisons, police), in the community, perpetrated by the state and in situations of armed conflict, refugee and/or displacement. In all of these situations gender power differentials and other inequalities play an important role in the dynamics of violence, and women may be particularly exposed to certain forms of violence as in the case of rape in armed conflict situations.

While recognizing the complexity of the issue and the many forms of violence against women that exist, this paper focuses on domestic and sexual violence against women. It provides an overview of the problem, its causes and its consequences, in particular as they relate to gender and health equity. It discusses some of the current controversies and dilemmas in the field and makes some policy and program recommendations for how to move forward.

2. DEFINITION AND MAGNITUDE OF THE PROBLEM

The United Nations Declaration on the Elimination of Violence Against Women, adopted by the UN General Assembly in 1993, provides a useful broad framework for defining violence against women, although more specific operational definitions are necessary for specific purposes such as monitoring. It defines violence against women as "Any *act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.*"

The Declaration also says that violence against women encompasses, inter alia, "*physical, sexual and psychological violence occurring in the family and in the general community including battering, sexual abuse of female children, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation, sexual harassment, and intimidation at work, in educational institutions and elsewhere, trafficking in women, forced prostitution, and violence perpetrated or condoned by the state*" (UN Declaration, 1993). All of these forms of violence are associated with power inequalities: between women and men, between children and their carers, as well as with growing economic inequalities both within and between countries. While recognising the many forms of violence against women that exist, this paper focuses on domestic and sexual violence against women.

A 1994 World Bank Discussion Paper *"Violence Against Women. The Hidden Health Burden"* provided the first global overview of the magnitude of the problem and its health consequences (Heise, Germain and Pitanguy, 1994). Since then, a growing number of studies looking at the prevalence of domestic violence against women[2], from both developing and developed countries have been published. Table 1 summarises prevalence data from some of the more recent studies (WHO, 1997).

- Insert Table 1-

It should be noted that these studies, while internally consistent, use different definitions of violence and measure different things. This makes it difficult to compare the figures across studies and countries. However, taken together, the data does indicate that violence against women, particularly domestic violence, is a significant and widespread problem that can be found in a wide variety of settings. The review of a selected number of well-designed, population-based surveys indicate that between 20% to over 50% of women report having been abused physically by an intimate male partner at least once in their lives (WHO, 1997).

Forced sex also appears to be a common occurrence. A 1998 Commonwealth Fund Survey on Women's Health in the United States reported that one of five women surveyed (21%), said they had been a victim of rape or assault (Scott-Collins et al, 1999). Here again, however, there are enormous variations in the definitions of rape and sexual abuse used in studies, which make it impossible to compare figures. Rates vary enormously depending on whether the definition of sexual abuse includes physical contact only or non-contact forms of abuse. They also vary according to the definition of rape and attempted rape used. For example, in many countries the legal definition of rape only includes penile-vaginal penetration. In addition, there are different forms of sexual coercion, which vary from culture to culture. Keeping these caveats in mind, it has been estimated that one in five women world-wide has been forced to have sex against their will (WHO, 1997).

Data on sexual abuse, particularly during childhood, is even more difficult to come by. Yet there is some evidence to suggest that it is far more common than had been thought previously. For example, a study in Barbados in a nationally representative sample of women and men aged 20 to 45 reported that 33% of women and 2% of men reported behaviour constituting sexual abuse during childhood or adolescence (Handwerker, 1993). A study in Switzerland found that 20% of women and 3% of men aged 13 to 17 had experienced sexual assault involving physical contact (Halperin et al, 1996). Several recent studies also document the extent to which the first sexual experience is unwanted or even forced. For example, in a national HIV/AIDS survey conducted in Central African Republic between September and December 1989, nearly 22% of female respondents reported that their first experience with intercourse was "rape" (Chapko, Somse and Kimball et al, 1999). A study of teenage mothers attending an antenatal clinic in Cape Town, South Africa (mean age: 16.3), found that 30% reported that their first intercourse was "forced" and 11% said they had been raped (Wood, Maforah and Jewkes, 1998).

The situation may be even more extreme when there is armed conflict, where mass movements and general insecurity and violence may contribute to an increase in rape and sexual assault, particularly but not only, of women. This is perhaps most extreme in intra national ethnic wars, where destroying the fabric of society is a major strategy. We have seen this recently in Rwanda and the former Yugoslavia, where rape was used systematically as a weapon of war (Swiss and Giller, 1993). It is well known that the increased risk of violence is likely to persist after the conflict is over, fuelled by the presence of firearms and other weapons. Accompanying the problem of conflict-related violence is the underlying domestic violence, which many of these women also experience. It has been suggested that domestic violence may increase during or following a conflict, but this is difficult to demonstrate given the lack of baseline information in most settings.

There are no reliable estimates of other forms of violence against women such as forced prostitution, and trafficking. However, there is anecdotal evidence that this may be growing, particularly in parts of Asia and the newly independent states in East and Central Europe. This increase as well as the growth of sex

tourism is fuelled by the growing disparities in wealth both within and between countries. It is often the poorest families who may have to sell off their daughters to be able to ensure the survival of the rest of the family. This is yet another example of the link between violence, poverty and inequity.

3. HEALTH CONSEQUENCES OF VIOLENCE: A GENDER AND HEALTH EQUITY CONCERN

The consequences of violence against women are far reaching. It impacts on all aspects of women's lives, their health and that of their children, and also on broader society. In addition, there are many ways in which violence perpetuates itself. Violence is sustained by inequality and in turn perpetuates inequality. For example, domestic violence is associated with poverty, but it also perpetuates poverty by, for example, reducing women's opportunities for work outside the home, their mobility and access to information, and children's schooling. It impacts on women's ability to care for themselves and their children, and is associated with self-destructive behaviours such as alcohol and drug abuse. Moreover, violence determines women's sense of self-worth, their sense of autonomy, their ability to feel and act as independent, capable women.

3a. Ill Health and Death

Violence against women, particularly domestic violence and sexual abuse, has been associated with many negative health consequences which are summarised below (see Figure 1). These include: injuries (ranging from cuts and bruises to severe injuries leading to permanent disabilities such as loss of hearing); sexually transmitted diseases; HIV/AIDS; unwanted pregnancy; gynaecological problems; chronic pelvic pain, sometimes associated with pelvic inflammatory disease; hypertension; depression; anxiety disorders; post-traumatic stress disorder; headaches; irritable bowel syndrome and various psychosomatic manifestations.[3]

- Insert Figure 1 -

Violence is increasingly recognised as a cause of injury among women, but its impact on women's mental health and on their sexual and reproductive health is less well recognised. Forced sex, whether by a partner or a stranger, can directly lead to an unwanted pregnancy or a sexually transmitted infection, including HIV/AIDS. Violence and/or fear of violence can also indirectly affect sexual and reproductive health, as they impact on women's ability to negotiate safer sex, including use of condoms, and their use of contraception. Data for the United States shows that an estimated 32,101 pregnancies are the result of rape each year, the majority of them among adolescents. Fifty percent of these ended in abortions and 5.9% placed

the infant for adoption (Holmes et al, 1996). There is a growing body of literature on the association between violence and mental ill health.[4]

Violence also occurs during pregnancy, with consequences not just for the woman, but also on the foetus or the infant. A review of studies from the United States found the prevalence of abuse during pregnancy to range from 0.9 to 20% with the majority of studies reporting a prevalence rate between 4% and 8.3% (Gazmararian et al, 1996). Violence during pregnancy has been associated with miscarriage, still birth, pre-term labour and birth, foetal injury and death (McFarlane, Parker and Soeken, 1996). Several studies have also found an association with low birth-weight (LBW.) For example, Bullock and McFarlane (1989) found significantly increased rates of LBW among battered women (12%) compared with non-battered women (6%), even after controlling for other variables like smoking, alcohol consumption, prenatal care and maternal complications. The same association was found in a study in Nicaragua (Momeni, Peña, Ellsberg and Persson, in press). Another study in India found a powerful association between women's experiences of "wife-beating" and infant and fetal loss, even after controlling for education and parity (Jeejeebhoy, 1998).

Violence against women can also lead to death. Deaths from femicide, as female homicide (sic) is increasingly being called, are usually much lower than homicide deaths in men. For example, in the Americas external causes are responsible for 51.7% of male deaths and 24.5% of female deaths. For men, the main external cause is homicide, accounting for 39.5% of the total, while for women homicide was the second external cause of death accounting for 23.2% of such deaths (PAH0, 1998). However, in women, death from homicide is known to be associated with a history of domestic violence. A high proportion of women are killed by people known to them, particularly partners and ex partners. Many of these deaths may take place around the time that a woman decides to look for help, or to leave the abuser. In the United States during 1992, 5,373 women died as a result of homicide, six out of every ten of them were murdered by someone they knew; about half were murdered by a spouse or someone with whom they had been intimate (Saltzman and Johnson, 1996.) Between 1976 and 1996, for persons murdered by intimates, the number of male victims fell an average 5% per year, and the number of female victims went down an average 1% (U.S. Department of Justice, 1998).

For many women, chronically beaten or sexually assaulted, the emotional and physical strain can lead to suicide. Research in the United States, Nicaragua and Sweden has shown that battered women are at increased risk of attempting suicide (Abbott, 1995; Bailey, 1997; Kaslow, 1998; Bergman, 1991; Rosales, 1999). These deaths are dramatic testimony of the limited options for some women facing a violent relationship.

3b. Use of Health Services

In industrialized countries there appears to be an association between victimization and use of health care services. For example, one study of a major HMO in the United States found that a history of rape and/or assault was a stronger predictor of physicians' visits and outpatient costs than was any other variable, including a woman's age or other health risks such as smoking (Koss, Koss and Woodruff, 1991). Women who had been victimized sought medical attention twice as often as non-victimized women in the study year, which was not the year the woman was victimized. The medical care costs of women who were raped or assaulted were 2.5 times higher than the costs of non-victims, after controlling for confounding factors (idem). There is little data from developing countries on this. While women may not seek help from health services, but rather from informal sources such as neighbours and family, they may be using health services for a range of violence-related health problems, such as depression, while the violence remains undetected.

The numerous health consequences of domestic violence are of relevance to health equity as they may increase the need for health care, while women may experience health care access problems. The 1998 Commonwealth Fund survey on women's health in the U.S. found that women who had experienced violence or abuse appeared to have greater difficulty accessing health care than other women (Scott-Collins et al, 1999). More than one third of those who had experienced violence or abuse reported at least one time they did not get needed health care.

3c. Consequences of Domestic Violence Against Women on Children

In addition to the direct impact of violence on the woman and her life, several studies indicate that domestic violence against women also impacts on their children, whether they only witness the domestic violence or are themselves abused. These consequences include behavioural problems, which are often associated with child management problems, school problems, and lack of positive peer relations (Jaffe et al, 1990). Children exposed to wife abuse also have a number of school adjustment difficulties, including dropping out of school

Jaffe reports the results of a study by Hughes of children residing in shelters, which showed that 55% of the sample of children studied were characterized as withdrawn and 10% were described as having made suicidal gestures. Other reports refer to a high degree of anxiety, with children biting fingernails, pulling their hair, and having somatic complaints of headaches and "tight" stomachs. Studies have also found that children who witnessed higher frequencies and intensities of wife abuse, performed significantly less well on a measure of interpersonal sensitivity (the ability to understand social situations and the thoughts and feelings of persons involved in those situations) than did those children exposed to less frequent and intense wife abuse. This in turn is associated with "high risk behaviours", such as unsafe sex in later life (Jaffe et al, 1990)

A review of U.S.-based research by the National Academy of Science states that "one third of

children who have been abused or exposed to parental violence become violent adults" (National Research Council, 1996). This is particularly the case for male children, whereas girls witnessing violence are more likely to end up as victims of violent relationships. Thus, it becomes difficult to separate causes from consequences, as growing up in a family where the mother is abused becomes an important way in which the cycle of domestic violence gets perpetuated. Furthermore, it serves to reinforce and perpetuate gender stereotypes and unequal gender relationships, which in turn will contribute to violence against women. Witnessing domestic violence also contributes to general violence, in that these children learn violence as the means by which to solve conflict.

In addition to witnessing, childhood victimization also perpetuates the cycle of violence in other ways. Childhood experiences of sexual abuse have been shown to be associated with low self-esteem, inability to say no to unwanted sexual relations and self-destructive behaviours including alcohol and drug abuse. It is also strongly associated with depression, other mental health problems and for subsequent abuse. A study in Barbados found that sexual abuse was the most important determinant of high risk sexual behaviour (Handwerker, 1993). After controlling for 17 possible confounding variables identified in prior studies, sexual abuse remained strongly linked to: the number of years sexually active before age 20, number of partners per five year interval, lack of condom use and history of STDs (Handwerker, 1993). Another study of 535 pregnant or recently delivered teenage mothers found that those abused before their first pregnancy, were more likely to have exchanged sex for money, drugs or a place to stay; were more likely to use alcohol and drugs during pregnancy; were less likely to use contraception and began intercourse one year or earlier on average than other study participants (13.2 vs 14.5 years) and considerably earlier than their non-pregnant peers (16.2 years) (Boyer and Fine, 1992.).

4. THE COSTS OF VIOLENCE AGAINST WOMEN

There is a limited amount of information on the costs of violence against women, although one may assume that these are substantial. There are the direct costs in terms of lives lost as well as the cost of the services provided such as health, legal, protection, and others. There are also indirect costs such as the days of work lost or reduced productivity due to violence, and its impact on the overall economy. There are many other indirect costs (sometimes called "intangible costs") which are mostly unaccounted for, as they are difficult to measure. These include the cost of lives shattered, of chronic pain, suffering, fear, depression, attempted suicides, loss of opportunities to pursue one's goals, and loss of self-esteem, among many others. While it may be useful to consider the economic consequences of violence against women, the social and human aspects are just as important to include in considerations of the cost of violence against women to society.

Laurence and Spalter Roth (1996) have reviewed the data for measuring the costs of domestic violence and the cost-effectiveness of interventions in the United States. They cite estimates for the cost of domestic violence in the United States ranging between $5 and $10 billion annually in losses due to domestic violence to $67 billion in a 1995 study on the cost of crime to victims. [5] They conclude that few studies include indirect costs and that even those limited to direct costs tend to be narrowly focused. Most studies consider only the costs of injury and deaths. However, there are costs not only to the victim, but to the families of victims, the resources and institutions of communities and societies at large, as well as costs associated with programmes for perpetrators. Furthermore, violence against women contributes to other problems like homelessness, foster care, and mental health problems, which are often not included in the calculations (Laurence and Spalter Roth 1996). More studies are now being done to come up with estimates for the cost of domestic violence. A recent one in Switzerland estimated the annual direct cost of domestic violence as 409,750,000 SwFr (equivalent to US Dlls 273,166,000 at the 1999 exchange rate of 1-50) (Yodanis and Godenzi, 1999).[6]

Another big knowledge gap in the domestic violence field is on the cost-effectiveness of interventions for domestic violence. To date there has been no attempt to document this (Laurence and Spalter-Roth, 1996.) Yet this is essential information to guide policy makers, funders and activists in the identification of effective, feasible and sustainable interventions to address this violence. Cost effectiveness studies can, by providing guidance on where resources can be used most efficiently, help to transform the understanding of violence against women into something actionable for decision-makers.

5. CAUSES OF VIOLENCE AGAINST WOMEN

In order to prevent and address a social problem like violence against women it is necessary to understand its causes. While many theories exist to explain violence against women, the understanding of its precise causes remains unclear. Studies have not been able to identify any specific personal and attitudinal characteristics that make certain women more vulnerable to battering, other than an association with having witnessed parental violence as a child (National Research Council, 1996). It appears that the major risk factor for domestic violence against women is being a woman. In other words this is a problem that affects women of all countries, social classes, religions, and ethnic groups. At the same time the rates at which this problem occurs does show variations across these variables.

Research over the last 20 years, mostly from the United States, has identified factors which are associated with violence against women. However, much of this research has tended to focus on single causal factors or tried to explain one causal theory of violence against women (social learning, feminist, family systems, structural), focusing either on the perpetrator or on the victim. Recently more complex models for

studying violence have been proposed, including multivariate statistical analysis. For example, when looking at the association between socio-economic status and violence against women, it is necessary to understand better which aspects of low socio-economic status are related to violence. Is it income, educational level, disparity between the husband and wife in terms of socio-economic status or resources, overcrowding or other variables? (Hoffman, Demo and Edwards, 1994.) It should be noted also that the literature on causal factors is mostly from developed countries and that much more work is needed to identify determinants and protective factors for violence in other settings.

Heise, in a recent article, builds on the work of others to propose "an integrated, ecological framework" for studying and understanding violence against women (Heise, 1998). This framework looks at factors acting at four different levels: individual, family, community, and social and cultural context. What is important about this model is that it emphasises the interaction between factors at these different levels. In other words it provides a model of embedded levels of causality in which there is not one single causal factor, but rather it is the interaction of factors operating at different levels that may promote or protect against violence. It is these factors and their interactions at these different levels that need to be better understood in different cultural contexts and settings. This will help to identify the different starting points and avenues for prevention and for other kinds of interventions.

5a. The Links Between Violence Against Women, Patriarchal Structures and Gender Inequality

Domestic violence against women is supported and/or re-enforced by gender norms and values that put women in a subordinate position to men. This cuts across all social classes, religion and education levels. While there are still variations by race, class, geography or region that need to be explained, unequal gender relations has been identified by feminists and other scholars as a cornerstone of domestic and sexual violence against women. The specific cultural context plays an important role in defining the mechanisms through which gender inequality and other factors affect violence.

Heise, in the article referred to above, reviewed existing research and summarized some of the factors related to violence that this research has identified, and organized them according to the levels of the ecological model she proposed. Many of the factors identified are closely related to norms and values around gender and social equity. For example, at the level of the family, male dominance and male control of wealth appear important, while at the macrosocial level, it is notions of male entitlement/ownership of women, masculinity linked to aggression and dominance, rigid gender roles, and acceptance of interpersonal violence as a means of resolving conflict (Heise, 1998).

The National Research Council review in the U.S.A. states that several studies support the fact that "men raised in patriarchal family structures in which traditional gender roles are encouraged are more likely to become violent adults, to rape women acquaintances, and to batter their intimate partners than men raised

in more egalitarian homes" (National Academy of Science, 1996 p62). Schuler and colleagues, studying violence against women in Bangladesh, point out that although most violence by men against women in Bangladesh occurs in the home, it does not originate or persist only within the home. Rather violence is one element in a system that subordinates women through social norms that guide their place and conduct (Schuler at al, 1996). Their research pointed out that violence is most frequent when women transgress or challenge the roles traditionally ascribed to them by society.

A study in an urban poor population in Mexico City similarly found that violence against women and the disorders related to it are embedded in their social relations, particularly with their male partners (Finkler, 1997). Finkler describes how traditional ideologies reinforce women's economic dependence on men, and notions about their domestic role and social inferiority, and how these ideologies are further transmitted through biomedical practice. While both men and women in the lower socio-economic strata are exposed to many forms of hardship and denigration, the power given to men by the prevailing ideologies and the use of physical violence against women generate what Finkler calls "life's lesions" in women. These are associated with sickness and she suggests that they account for the many sub-acute non life threatening conditions which women in developing countries present with to health services and which are not easily amenable to biomedical remedies (Finkler, 1997).

Cross-cultural anthropological and ethnographic studies of violence against women, such as that of Levinson (1989) and the review of 14 cultures by Counts, Brown and Campbell (1992), also identify the role of social and cultural mores, including those around gender relations, in the acceptance and promotion of violence against women. Counts et al found that the presence and severity of wife beating ranged from very frequent to almost non existent, although physical chastisement of wives was tolerated and even considered necessary in most societies. They identified that the presence of 'sanctions' against violent behaviour and/or 'sanctuary' for women experiencing violence, eg. the family and community being able to intervene in marital disputes/violence was associated with low levels of violence and vice-versa. Cultures with a 'macho' concept of masculinity associated with dominance, toughness or male honour also were found to have higher overall levels of violence against women (Campbell, 1985).

Cultural norms around violence, gender and sexual relationships are not only manifested at the individual level, but are also re-enforced or not by the family, the community and the broader social context, including the media. Dobash and Dobash (1992) have shown how historically husbands' domination over wives, including the use of violence, has been sanctioned by cultural beliefs. In many settings violence is considered "normal" and a prerogative of men/husbands. The socialization of boys and girls often reflects related cultural norms and values. Males are encouraged to be aggressive and sexually active, while girls are taught to resist sexual activity and be "sugar and spice". Disturbing data from several countries show that the first sexual act is often experienced by girls as forced, accepted out of fear

of violence (Wood and Jewkes, 1997). This highlights the need to address social norms and attitudes that promote unequal gender and sexual relationships, starting with children and adolescents. It is important to understand how these social norms that condone and legitimize violence against women contribute to high levels of violence, in order to devise interventions against them.

5b. Witnessing Violence

Exposure to domestic violence between parents when growing up has been shown to be associated with domestic violence against women in studies from Nicaragua (Ellsberg et al, 1997), Cambodia (Nelson and Zimmerman, 1996), Canada (Johnson, 1996) and in the U.S.A., described earlier. One third of children who have been abused or exposed to parental violence become violent adults and sexual abuse in childhood has been identified as a risk factor in males for sexual offending as an adult (National Research Council, 1996).

A critical review of 52 studies conducted in the U.S. that included comparison groups by Hotaling and Sugarman (1986) found that the only risk marker for women consistently associated with being the victim of physical abuse was having witnessed parental violence as a child. As regards sexual assault, Koss and Dinero (1989) concluded that it was generally not predictable, but to the extent it could be, was accounted for by variables that represent the after effects of childhood sexual abuse, including influences on drinking, sexual values and level of sexual activity (National Research Council, 1996). This has been found in other studies such as the one in Barbados mentioned earlier (Handwerker, 1993.)

In reviewing such studies it is important to note that although witnessing increases the risk of continuing patterns of violence it does not pre-ordain it. As Johnson states, "While it is true that the rate of wife beating is much higher for men who have witnessed violence by their own fathers, it is also true that the majority of abusive men were not exposed to violence in childhood. And, over half the men who did have this exposure have not been violent toward their own wives" (Johnson, 1996 p.177).

5c. Alcohol

Alcohol merits some mention since research has consistently found heavy drinking patterns related to intimate partner and sexual violence. However, the exact relationship between alcohol and violence remains unclear (National Research Council, 1996). Many people drink without engaging in violent behaviour and many battering incidents and sexual assaults occur in the absence of alcohol. However some evidence exists that violent men who abuse alcohol are violent more frequently and inflict more serious injuries on their partners than do men without alcohol problems (Frieze and Browne, 1989 in Heise, 1998.) Addressing violence in alcohol dependence treatment programmes can be useful potentially to help reduce the incidence and severity of assaults, but not necessarily to end the violence.

6. PROTECTIVE FACTORS

Studies have identified risk factors as well as factors that appear to be protective or mitigate violence. These can also provide important leads for the development of interventions. A study in Nicaragua documented the importance of having family that can respond or intervene when the violence occurs (Ellsberg et al, 1996). In Bangladesh belonging to a credit programme was associated with lower levels of domestic violence by both channelling resources to poor families through women and by organizing women to participate in regular meetings and exposure to outsiders (Schuler, 1996). The researchers noted that more could be made of this by the credit programme organizers through, as a minimum, more awareness raising and openness to discussing the issue. Globalization and the growing urbanization of developing countries however, may be contributing to the disappearance of some of these protective factors. They contribute to the isolation of women from their extended families and have also attenuated community sanctions (Finkler, 1997). Understanding and supporting traditional sources of support and or remedy could be important interventions, particularly in resource poor settings.

7. DISCUSSION OF CURRENT POLICY RESPONSES: LIMITATIONS AND SOME PROPOSALS

The paucity of information on risk and protective factors is a major constraint to the design of locally relevant programmes and policies. More work needs to be done in this area. Until very recently, most of the response to violence against women, including the provision of care and support services has been provided by the non-governmental, voluntary sector, particularly women's organizations. Shelters for battered women and rape crisis centers are classic examples, and in many developed countries still form the basis of services for women experiencing violence, albeit with varying levels of government funding. A few countries, mostly in the North, have government policies and coordinating mechanisms that provide a framework for action, but in most the responses remain ad hoc. Following the Fourth World Conference on Women in Beijing, a number of developing countries, particularly in Latin America, have passed domestic violence laws. This is an important step, but much remains to be done before these laws can realistically be put in practice. Furthermore, legal reform is only one of the many changes needed to address violence against women.

There is currently a growth in projects aimed at developing and/or improving the response by the formal sectors towards women experiencing violence. Interventions have traditionally focused on the police, the legal and judicial system (judges and others), and increasingly the health sector. Mostly they involve training to improve the identification and response to women experiencing violence. There are several limitations to this approach:

a) Training is often an isolated intervention, with little follow-up. It becomes the end rather than the means.

b) Training is focused exclusively on technical content and does not address the attitudes and values of the providers. For example, a health care setting which is not welcoming and where women are not treated respectfully or listened to, as a matter of course, can hardly provide an appropriate environment for addressing violence against women.

c) Institutions such as the police, and the legal and health systems reflect the same gender stereotypes and prevailing norms that underpin this violence in society. Occasionally the training may include looking at the social construction of gender and power relationships, but most often it does not and training programmes rarely address the structural barriers that may make it difficult to put the training into practice. In the case of the health sector, many providers may feel that addressing violence is beyond their reach. They may lack basic knowledge, time or empathy, or simply not know what to do or where to refer those women. In many situations, they may be experiencing violence themselves.

Basic information on domestic violence and sexual assault needs to be systematically included in all medical and nursing curricula in order to, as a minimum, raise awareness of the fact that the problem exists. Training programmes in health care settings would be most useful if they address broader issues of interaction and communication with patients, and gender and sexuality, rather than focusing exclusively on violence. In order for training to be effective, there must be long-term goals and strategies to ensure that the necessary structural changes accompany the training. This requires political and administrative commitment, and the development of policies and protocols for the different levels of providers.

d) The focus is on the service rather than the woman. Health providers, particularly doctors, often feel that they have 'to make things right'. This may lead to judgmental attitudes and undue pressure on the woman to leave the violent relationship or situation. Providers must learn to listen and treat women as the experts, delicately balancing the provision of support and guidance and a concern for women's safety with respect for their decisions, even if this is to stay with the violent partner. She may judge that this is the safest option and in many cases will be right. This fine line is a difficult one, which those working in this area must learn to walk.

While the provider usually focuses on the battering, for the woman this is often only one aspect of a complex relationship and her interpretation of the situation is coloured by this different understanding. She may be balancing the risks of staying in the relationship with those of extreme poverty for her and her children or with being ostracised by the family and others. While individual women require and should have high quality care for the consequences of violence, it is important to keep in mind that the underlying

problem is male violence. It is important that providers and the institutions that are meant to help her, give a clear message that the violent behaviour is not acceptable and that women do not deserve to be abused in any circumstance.

8. WHAT ABOUT THE MEN: A GENDER PERSPECTIVE ON VIOLENCE?

This question inevitably comes up when working on violence against women. The arguments go various ways: "Why give so much attention to women when men die much more from violence?" "Why are you focusing only on women; you will never address violence against women if you don't involve men."

While it is becoming more common to talk about violence against women, it remains a sensitive issue at many levels. Many men may feel uncomfortable discussing an issue, which at times seems to reflect on men in general, portraying all men as aggressive, violent, irresponsible, wife beaters or sexual predators. Women can be and are violent and many men are not violent. Men are also frequent victims of violence, particularly young men, with homicide a major cause of death amongst 15-44 year old men. (PAHO 1998). However, most violence is perpetrated by men, whatever the age and sex of the victim. As has been discussed in this paper, girls and women suffer violence primarily in the hands of men they know and in the context of an intimate relationship. A gender perspective on violence is often equated with a focus on violence against women and girls. However, a gender perspective is helpful to the violence field more broadly. It is important to understand the difference in the forms and nature of violence that women and men experience, and how the socialisation of women and men contributes to violence.

A review of literature on crime and violence cited by Barker (1999), concludes that masculinity has been seen as inherently violent and that the impact of gender socialisation on men has largely been ignored in the study of violence (Messerschmidt, 1993). Some of the literature suggests that while girls are usually socialised closer to home, young men tend to find their peer support on the street or outside the home. Maleness is defined in many cultures in "macho" terms of bravado, aggression and control and dominance of women or others who are considered weaker. Many cultures condone aggression as a means for males to express anger. In some cultures there may also be rigid codes around "family honour" leading to so-called "honour killings" of women who have been raped, usually by male members of their own family.

Barker postulates that in low income settings, where mainstream sources of masculine identity such as educational achievement or stable employment are difficult to access, young men may be more inclined to adopt violence or other behaviours of control as a way to prove their manhood. A better understanding of how masculinities are shaped in different environments would be an important contribution to the field of violence and not just to violence against women.

In terms of prevention and other interventions, it is certainly important to have more men address violence against women as an issue and to take some responsibility for changing the social norms and values that allow this gross violation of human rights to go on unquestioned (Piot P, 1999). However, at the same time it is necessary to critically assess the approaches being used, and to ensure that resources to address the issue are allocated in the most effective way and are not diverted from the hard-won program efforts of many women's organizations. Over the last twenty years it has been these organisations that have provided basic care and support to women experiencing violence and their children, and increasingly work on prevention and even programs for batterers. The growing interest in men's groups working on violence against women does not always recognise that changing the norms and values of relationships from those of control and dominance to those based on mutual respect and equity requires not only individual but also structural change.

Like with women victims, there is no one profile of men that defines who will or will not be a batterer other than having been exposed to violence as a child. Thus, interventions that focus on working with children of women experiencing abuse, may be an important prevention strategy with an impact on the children themselves, but also on decreasing violence and improving health and wellbeing of the men and women of the future. School programmes starting at an early age that help to shape and promote more equitable gender relations and non violent forms of conflict resolution may be important interventions to initiate change in the prevailing norms. Teaching of non-violent parenting may be another important avenue to develop further as an intervention for the prevention of violence. (Beaglewood R, personal communication).

However, the most common intervention so far for men has been batterer intervention programmes (BIPs). Batterer intervention programmes (BIPs) aim to change the behaviour of batterers. They were initiated in the 1970s and have tended to focus on group rather than individual treatment. They vary in length, but tend to be relatively short, usually around 20-30 weeks. In many cases in the United States they have become court-mandated in lieu of incarceration.

BIPs have often not been systematically monitored and evaluated, limiting the knowledge about the effectiveness of these interventions. Some research suggests that overall BIPs appear to contribute to the cessation of physical domestic violence in around 53% to 85% of men who complete the prescribed intervention (Austin and Dankwort, 1999). However, there are many methodological limitations to these studies, including lack of control groups, different outcome measures, small sample sizes, and different post treatment follow-up period (National Research Council, 1996). Another problem is that there tends to be a low compliance rate, except in those cases where it is mandated by the law. Most studies show a drop out or non engagement rate of about two thirds of the rate of completers and a majority of men do not come back after the first session

Furthermore, the evaluations that do exist have focused on the reduction of violence rates as reported by batterers themselves – and at times confirmation by their spouses-, but have not considered the well-being and safety of women, or whether they are empowered or disempowered by such interventions (Austin and Dankwort 1999.) Several reports show that while men had stopped the physical abuse after participating in a BIP, the verbal and psychological abuse may continue or get worse (Edleson, 1990.) This highlights the need for BIPs to address not only physical but also psychological abuse and other forms of control. These programmes should have a strong focus on women's safety, and on addressing gender roles and power inequalities.

9. CURRENT CONTROVERSIES AND DILEMMAS

a) Violence Against Women: Health Problem or Risk Factor?

In the bio-medical model, violence is usually classified as intentional injury, at times even included under non-communicable diseases. However, when developing a system for conceptualising the causes and consequences of violence, it is important to consider the different nature and patterns of violence that are most commonly experienced by men, women and children.

It is well known that men most commonly experience physical violence from other men (strangers or acquaintances), mainly outside of the family context. Physical injury or death are the most common outcomes. In contrast, most of the violence women and girls suffer is from men they know, often in the family/home. This may have physical, sexual and/or psychological dimensions, may continue for years and may escalate in severity over time. Physical injury is frequently not the primary outcome, and may not even be an outcome of the violence. Nevertheless there may be many other important negative health consequences, including sexually transmitted diseases, unwanted pregnancy, depression and numerous other mental health problems, gastrointestinal disorders, and various psychosomatic problems, as discussed in the section on health consequences.

While physical injury may serve as an appropriate proxy for violence among men, it does not provide a broad enough framework to describe and understand many other common forms of violence, such as child abuse, domestic and sexual violence against women, and abuse of the elderly. It is clearly important to recognise violence as a cause of injury, but a focus on injury limits the understanding of the many forms of violence that occur and their multiple health consequences.

Violence against women may best be conceptualised as a risk factor for ill health since its consequences cut across a range of women's health outcomes. This provides a clearer understanding of its multiple health consequences, the synergies between them, and the potential benefits of different forms of prevention activities. It also points to various possible channels in the health system through which to identify

women in need of help; not only in accident and emergency departments, but, for example, in psychiatric services, antenatal care services, and STD clinics.

The focus on injury may also inadvertently contribute to minimising the understanding of the impact of violence on women's health and lives. The profound consequences of violence on women's mental health have frequently been ignored. Yet there is increased documentation of a strong association between a history of domestic abuse and psychiatric problems, particularly depression, anxiety and post-traumatic stress disorder (Campbell, 1985, Koss, 1990). In some countries, particularly in Latin America, whether an act of violence is considered criminal and there can be legal recourse or not often depends on the type and the severity of the physical injury. Research in Nicaragua has documented how men learn to modify their behaviour in order to fit the law by, for example, giving blows where it will not show (Ellsberg, 1997).

b) Definition and Measurement Issues

There is no universally accepted definition of violence against women. Some would argue for a broad definition that includes any act or omission that causes harm to women or keeps them in a subordinate position. This would include what is sometimes referred to as "structural violence", for example poverty and unequal access to health services and education. The benefit of a broad definition is that it places gender-based violence in the broader social context (Richters 1994) and allows interested parties to bring attention to most breaches of women's human rights under the rubric of violence against women. The drawback is that by creating far-reaching meanings, a definition's descriptive power is lost. An expert consultation in WHO agreed that issues of structural violence would be dealt with best under discrimination (WHO, 1996.) The definition in the United Nations Declaration on the Elimination of Violence Against Women, adopted by the General Assembly in 1993, included at the beginning of this paper, provides a useful conceptual and advocacy framework, but more specific operational definitions are needed for research, surveillance and monitoring.

The cross-cultural applicability of definitions is one of the issues that arise in the context of international studies. Anthropologists and women's health advocates have highlighted the difficulties of creating international classifications, as concepts of what constitutes violence against women vary profoundly across cultures. Because universal classification systems cannot fully account for the variance that exists between cultures they need to be used with caution (WHO, 1996). All societies have forms of violence that are tolerated, or at times even encouraged by social norms and customs. Whether socially condoned or not, these acts as well as their effects on women's health and lives, need to be recorded. Addressing only culturally unacceptable forms of violence fails to meet the spectrum of women's needs.

Researchers have partially overcome this issue by focusing on the measurement of specific behaviours or acts and their effects on women's physical, sexual and emotional well-being. Specific

instruments such as the Conflict Tactics Scale (CTS) and the Spousal Abuse Index have been developed along this vein, and a modified version of the CTS in particular is increasingly being used for research in developing countries.[7]

c) Limited Knowledge and Lack of Funding for Research

As is evidenced by this review, the majority of the published literature on violence against women comes from northern countries, particularly the United States. While there are a number of recent prevalence studies on domestic violence against women from developing countries, data from these countries remains scarce. There is a need for prevalence and incidence data that is comparable across-cultures and that also starts to elucidate the determinants as well as the protective factors, which operate in different settings. This research is essential to improve our understanding of the magnitude and the nature of the problem, to provide guidance to the development of interventions and to be able to monitor their impact. It will also provide baseline data from which to understand trends and patterns.

A Multi-Country Study on Women's Health and Domestic Violence, co-ordinated by WHO, aims to fill this gap by developing methodologies to measure violence against women and its health consequences cross-culturally, and by implementing such research in six countries (WHO, 1999). The protocol and questionnaire for this study build on the experience of many researchers who have been particularly concerned with methodological and ethical issues, some of whom come together in the International Network of Researchers on Violence Against Women (IRNVAW.) WHO has also produced Ethical and Safety Recommendations for Research on Domestic Violence (WHO, 1999.)[8]

There is also a need for interventions research: to identify what works and what doesn't in different settings, and what is sustainable and feasible in resource poor settings. While funds are more or less made available to support bio-medical research to identify treatments or cures for specific diseases, there appears to be less interest to support research to identify the effective intervention or package of interventions for an issue like violence against women. This raises a question of how research funds are allocated; who sets the research agenda, and how much are gender equity concerns genuinely integrated into these agendas. Well designed and action-oriented research can in itself be an intervention by, among other things, raising awareness of the problem and initiating public discussion as well as collaboration across sectors. It needs to be supported in order to establish the most cost-effective and efficient response to violence, particularly in resource poor settings.

d) Medical Versus a Public Health Approach

The focus of many of the efforts of women's organisations and others, understandably, has been on responding to the needs of women experiencing abuse. Yet, dealing with the victims of violence is only the

"tip of the iceberg". Responding to the needs of individual women experience violence is of course necessary. It may also serve to prevent the reoccurrence of violence or further health consequences, death or disability. However, it is necessary to pay equal or more attention to the search for strategies for primary prevention

A public health approach focuses on prevention and emphasises opportunity for early intervention. It is based on science, includes a social analysis of health, and an interdisciplinary approach, all of which are essential to addressing the problem of violence against women. Work in this area needs to be based on sound data describing the magnitude and nature of the problem, the risk and protective factors, and the evaluation of interventions for their effectiveness, feasibility and replicability.

Preventive strategies need to be context specific, and address the particular risk factors that are relevant to each setting. Important elements in prevention are interventions to change the social norms and values that discriminate against women and that condone for example, the physical chastisement of women by their husbands. Some places have started "Zero Tolerance Campaigns" which use mass media and other information and education channels to promote a culture that does not tolerate violence against women or children. Another approach has been the use of community "sanctions" as a deterrent for men to abuse women. Examples such as the beating of pots outside of the house of an abuser by women in India, neighbourhood watches and whistle blowing in Peru or other strategies to identify and shame an abuser, are creative ways of thinking of sanctions. In many situations these may be more effective than using the formal sanctions of the police and judiciary, which can often act against women.

Behaviour change is never easy and it is a long-term process, as anyone who has attempted a change, however small, can testify. There is, however, a growing body of experience on behaviour change in relation to prevention of HIV/AIDS and of smoking, where public health and health promotion have been harnessed to achieve this change. Those working on violence against women need to build on this knowledge and apply it to changing attitudes, values and beliefs that serve to perpetuate violence against women. There are also difficulties in measuring the impact of many of these preventive strategies. So far, few evaluations exist of the effectiveness of these programmes, so it is essential that any intervention programmes build monitoring and evaluation into their work.

e) Limited Models for Interventions

Models for interventions come mostly from the developed world and in many cases these are inappropriately copied in settings where the conditions for them to be effective are not present. For example, the recommendation for universal screening of women in health centers, while very useful in settings where services for referral exist and doctors have been trained to deal with violence, may not be helpful and can even be damaging in other settings. Furthermore there is little or no evidence on which to make these

recommendations. It is necessary to assess critically the evidence for the effectiveness of any interventions proposed and to consider their appropriateness and sustainability in different settings, rather than making broad global recommendations.

The role of the health sector in both prevention and in responding to the needs of survivors of violence needs to be better defined. The health sector may not be the most appropriate sector to initiate work in this area in all settings. Specific contextual analyses and pilot projects are urgently needed to test strategies and identify what works in different settings. In terms of care it is important to tread a fine balance between encouraging the involvement of the health sector, while at the same time not medicalizing the problem. The gender biases inherent in the health system may act as barriers to an appropriate response and it will be necessary to address these in order to respond appropriately to the needs of individual women.

f) Lack of Multi Sectoriality

There is recognition of the need for a well co-ordinated multi sectoral response to violence against women. However, it remains the case that the entry point is usually through one sector and there are as yet few examples of where this approach has been successfully put into practice. It is necessary to pilot models for an integrated response to violence against women, and document their effectiveness as well as the obstacles that they are likely to encounter. One such model for an integrated response at the community level is currently being piloted in Latin America by the Pan American Health Organization (PAHO) and the Inter-American Development Bank (IDB). This model aims to create co-ordinated community networks where the health system, the legal system, police, churches, NGOs and other community-based groups meet regularly to design and implement a co-ordinated response to domestic violence. At the national level it seeks to promote the adoption of laws and policies to strengthen institutional capacity to respond effectively to domestic violence. It also fosters linkages with mass media to challenge the social attitudes and beliefs which grant men the right to control female behaviour and to communicate that violence is unacceptable (WHO, 1997)[9]. These types of pilot models should be monitored in order to assess their replicability in other regions.

g) Forensic Medicine: The Intersection of the Health and Legal Systems

There is a need to address specific issues on which the response of the health sector to women's needs is grossly inadequate such as the forensic medicine system. In many countries the medical system, particularly forensic doctors, may act as a barrier for women trying to access the legal system. (Prasad, 1999) [10] It may be that by law only forensic doctors can provide evidence in court, even though only a handful of these doctors exist. Even where they exist in reasonable numbers, women may face many access barriers such as lack of time and money, distance, lack of information, language, and others. A woman in a rural area who has been raped and would like to take legal action against the perpetrator stands very little

chance of being able to produce the required evidence. Even where any doctor can provide evidence, most doctors are not trained in how to collect evidence properly and in a manner that does not revictimize women. They may also be reluctant to get involved in a court case. The lack of an appropriate quality service to provide care and collect evidence in cases of rape and sexual assault or other forms of assault disproportionately affects women and is therefore another dimension of health inequity in service provision.

h) Legal and Human Rights Framework

Violence against women is much more than a health issue; it is an infringement of women's human rights, for example, the right to bodily integrity. It also impinges on their ability to exercise other human rights, such as the right to the highest attainable standards of health, and their sexual and reproductive rights. Violence is reinforced and condoned by the many forms of discrimination which women experience in society. Many countries still need to ratify human rights conventions such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which provides the framework for revising laws that will begin to support the redress of existing inequalities between women and men, and problems like violence against women.

10. SUMMARY CONCLUSIONS

1. Violence against women is a widespread problem in all societies. It is a violation of women's human rights and also a public health problem. It has consequences on all aspects of women's life, including their health, increasing their risk of many physical and mental health problems and of death.

2. Violence is caused and perpetuated by different kinds of inequality: primarily between women and men, but also socio-economic inequality both within and between countries. It is mostly perpetrated by men, regardless of the sex of the victim. Women and girls experience violence primarily from men they know and in the context of families. In most cases violence is part of a continuum of controlling behaviours by a usually male partner or ex partner over the woman. It is therefore essential to understand the role played by the unequal balance of power between women and men in relationships and in society in perpetuating violence, and identify ways in which this can be redressed.

3. The causes of violence are multi-factorial and complex. While gender is critically important, there are variations across race, class and regions. There is a need for a better understanding of the risk and protective factors that operate in different contexts and on this basis to develop pilot interventions which can be monitored, evaluated and costed.

4. A public health approach to addressing violence is an important contribution. To address violence requires collaboration among many sectors, such as education, health, legal and judiciary, police, and the church and other community-based organizations. It is important to identify clearly the specific contributions that each sector can make, and what the most appropriate entry point is in different settings. The non-formal sectors (eg. churches, neighbourhood associations, women's groups,) can play a role that is as important, if not more, than some of the formal sectors and should be thoroughly involved.

5. More attention needs to be put into identifying effective preventive measures, harnessing public health and health promotion is the difficult and long-term task of changing attitudes, norms and behaviours that condone or even promote male control over and violence against women. The promotion of more equitable and responsible gender relations, starting at an early age, is an important element of violence prevention. Work in this area needs to be approached in a more systematic manner, with proper monitoring for effectiveness and impact.

6. For as long as we cannot prevent violence we will continue to need to provide care for women who are experiencing abuse and for their children. Thus health providers and others need to be supported to identify and respond appropriately to the needs of these women. Any intervention must respect a woman's autonomy and her right to decide for herself what she decides is the most appropriate way to resolve her problem. It is important to identify strategies of resilience that women use and support these in whichever ways is possible.

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ENDNOTES

[1] The data available to estimate the extent of violence in general, and violence against women in particular, is grossly inadequate. There are many reasons for under-reporting and much of the data obtained from services is incomplete and often unreliable. Published studies come mostly from the United States, Canada, Australia and some European countries with very few from poorer countries. Furthermore, many of the studies have methodological design problems or use clinic based samples which make it difficult to obtain reliable estimates of prevalence.

[2] We have chosen the term domestic violence against women as it is commonly used in the United States literature. Other terms used in the literature to describe this phenomena are violence by intimate male partners and violence against women in families.

[3] For more information on the health consequences of violence against women, see Heise LL, Germain A and Pitanguy J (1994); Heise LL in Koblinsky, Timyan and Gay (1993); Resncik HS, Acierno R and Kilpatrick DG (1997).

[4] See for example, Mullen PE et al (1988); Ellsberg M et al (1999); and Campbell J, Kub J and Rose L (1996) *JAMWA* 51(3): 106-111;

[5] The wide variation is due to the different methods used to estimate the costs of violence and the inclusion of different kinds of costs in the studies.

[6] For other studies on the costs of domestic violence see Greaves 1995, Day 1995 and Kerr 1996 from Canada; Stanko 1998 from Great Britain, and Blumel 1993 from Australia. No attempts have been done to quantify this in developing countries.

[7] For more information on the Conflict Tactics Scale see Straus MA et al (1996). For adaptations of the CTS see for example the WHO Multi-country Study on Women's Health and Domestic Violence Protocol WHO/EIP/GPE 99.3

[8] The WHO Multi-Country Study is being implemented in Bangladesh, Brazil, Japan, Namibia, Peru, and Thailand. Discussions are underway with other countries. For more information on this study you can contact Dr Garcia Moreno in WHO at garciamorenoc@who.ch.

[9] For more information on this project you can contact the Women, Health and Development Program in PAHO (Velzebom@paho.org)

[10] The Women's Human Rights Project of Human Rights Watch has commissioned reviews of the forensic legal systems in Pakistan, Peru, Russia, and South Africa.. The reports can be obtained directly from Human Rights Watch.

TABLE 1: PREVALENCE OF DOMESTIC VIOLENCE AGAINST WOMEN

Switzerland Gillioz et al (1997)	Sample of 1,500 women, aged 20- 60, in a relationship.	20% report being physically assaulted.
United Kingdom Mooney (1995)	Random sample of women in the London Borough of Islington.	25% of women had been punched or slapped by a partner or ex-partner in their lifetime.
Cambodia Nelson and Zimmerman (1996)	Nationally representative sample of women and men, aged 15-49.	16% of women report being physically abused by a spouse; 8% report being injured.
Korea Kim and Cho (1992)	Stratified random sample of entire country.	38% of wives report being physically abused by their spouse in the last year.
Egypt El-Zanaty et al (1995)	Nationally representative sample of ever married women, aged 15-49.	35% of women report being beaten by their husband at some point in their marriage.
Israel Haj-Yahia (1997)	Systematic random sample of 1,826 married Arab women (excluding Bedouin) in Israel.	32% of women report at least one episode of physical abuse by their partner during the last 12 months; 30% report sexual coercion by their husbands in the last year.
Uganda Blanc et al (1997)	Representative sample of women, aged 20-44, and their partners in two districts, Masaka and Lira.	41% of women report being beaten by a partner, or physically harmed by a partner; 41% of men report beating their partner.
Zimbabwe Watts (1996)	Representative sample of 966 women over 18 years in Midlands province.	32% report physical abuse by a family or household member since the age of 16.
Chile Larrain (1993)	Representative sample of women, aged 22-55, from Santiago, in a relationship for more than two years.	26% report at least one episode of violence by a partner, 11% report at least one episode of severe violence and 15% of women report at least one episode of less severe violence.
Mexico Rodriguez and Becerra (1997)	Representative sample of 650 ever married/partnered women from Metropolitan Guadalajara.	30% report at least one episode of physical violence by a partner; 13% report physical violence within the last year.
Nicaragua Ellsberg et al (1996)	Representative sample of ever-married women, aged 15-49, from Nicaragua's second largest city, León.	52% report being physically abused by a partner at least once; 27% report physical abuse in the last year.

Source: WHO, Geneva (1997) Violence Against Women: A Priority Health Issue. WHO/FRH/WHD/97.8

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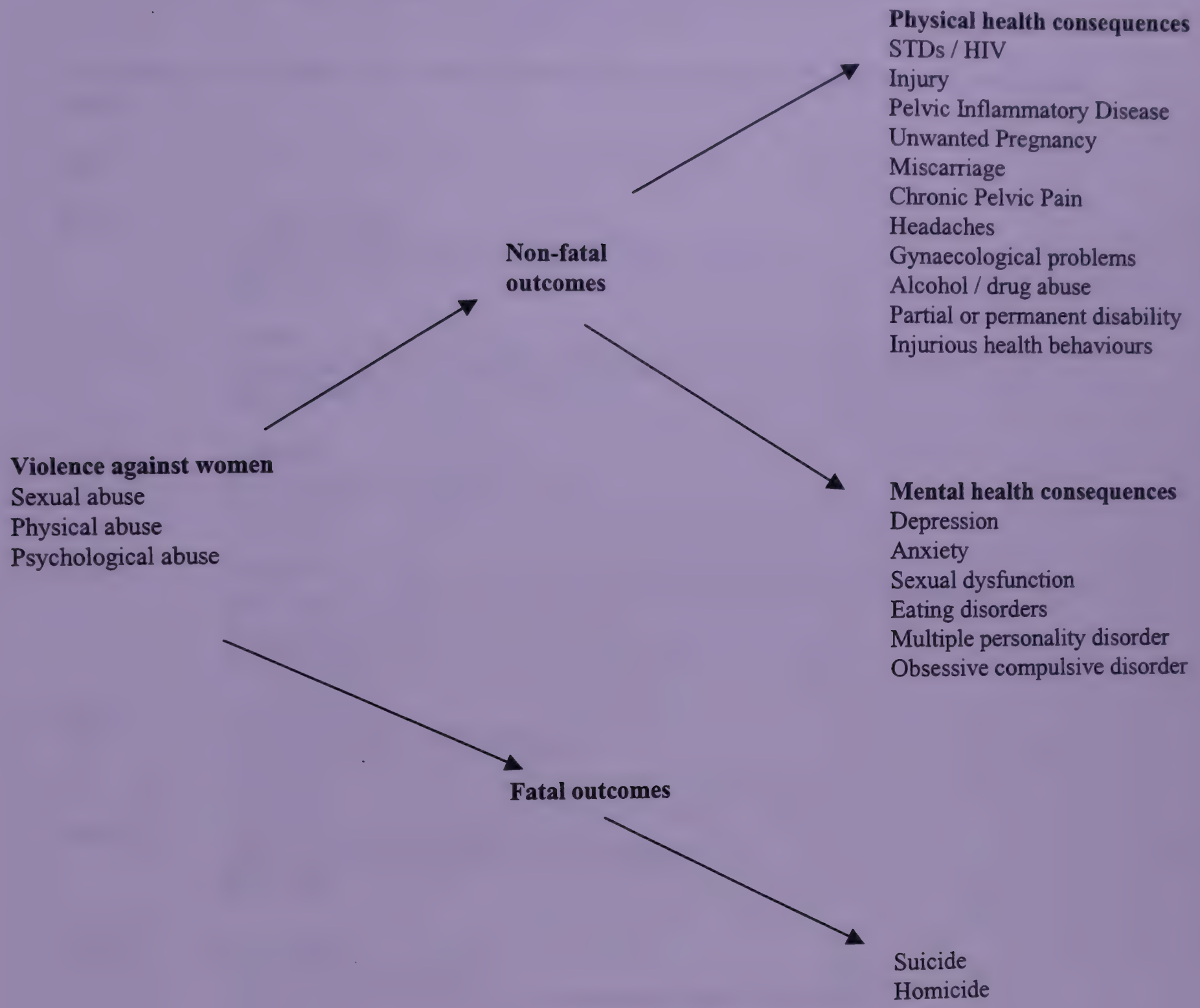
Watts C, Ndlovu M, Keogh E. (1997) The magnitude and health consequences of violence against women in Zimbabawe. Musasa project Report

FIGURE 1: HEALTH CONSEQUENCES OF VIOLENCE AGAINST WOMEN



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